No. 4 July, 1915. Vol. VIII.

Bulletin

OF THE

Ontario Hospitals for the Insane

A Journal Devoted to the interests of Psychiatry in Ontario

Printed by Order of the Legislative Assembly

FOR THE DEPARTMENT OF THE PROVINCIAL SECRETARY.

Printed by L. K. CAMERON, Printer to the King's Most Excellent Majesty.

Every medical practitioner in Ontario is invited to interest himself in the success of the Hospital for the Insane in the district in which he resides. Every Superintendent realizes that the successful results aimed at in the modern treatment of the insane can be more readily secured by enlisting the co-operation and sympathetic support of the medical men who were formerly the physicians to the patients in their homes. The family Physician naturally watches with interest the course of the hospital treatment and should consider himself an honorary member of the visiting staff of the hospital to which his patients are sent for treatment.

PROCEDURE TO SECURE ADMISSION OF PATIENTS.

The Provincial Secretary desires that all cases that are likely to be benefited by treatment in a Hospital for the Insane should be admitted with the least possible delay.

(1) Where the property of a patient is sufficient, or his friends are willing to pay the cost of the Medical Examination, the family Physician should apply directly to the Medical Superintendent of the Hospital for the Insane, in whose district the patient resides, for the necessary blank forms. These being secured, they should be properly and fully filled in, dated, signed in presence of two witnesses by the medical men in attendance. They are then returned to the Hospital, and if satisfactory, and there is accommodation, advice will be sent at once to have the patient transferred.

(2) Where the patient has no property, and no friends willing to pay the cost, application should be made to the head of the Municipality where he lives, who, after satisfying himself that the patient is destitute, may order the examination to be made by two physicians, and a similar course to the above is then followed. The Council of the Municipality is liable for all costs incurred, including expenses of travel.

(3) Where the patient is suspected to be dangerously insane, information should be laid before a magistrate, who may issue a warrant for the apprehension of the patient and if satisfied that he is dangerously insane, may commit the patient to the custody of someone who will care for him, but not to a lock-up, gaol, prison or reformatory, and notify the Medical Examiners. The Magistrate should then send to the Inspector of Prisons and Public Charities, Parliament Buildings, Toronto, all the information, evidence and certificates of insanity. The costs incurred by this method form a charge against the County, City or Town in which such patient resided.

Voluntary Admission.

The Superintendent of a Hospital for Insane may receive and detain as a patient any person suitable for care and treatment who voluntarily makes written application on a prescribed form, and whose mental condition is such as to render him competent to make application.

A person so received shall not be detained more than five days after having given notice in writing of his desire to leave the hospital.

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The Bulletin

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Ontario Hospitals for the Insane

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THE RELATIONSHIP OF THE HOSPITAL FOR INSANE TO THE GENERAL PRACTITIONER.

By Dr. Harvey Clare.

Statistical investigations have shown that in the older European countries the proportion of people suffering from psychoses is to the total population as 1 to 250; someone has said 1 to 280. In Ontario the population at the last census was two million five hundred thousand, and at the close of last year we had six thousand residents in the Hospitals for Insane. This figures out 1 in 420. You will see by these figures that our newer country has not the same proportion of mental diseases, or rather, if we have, that many cases of mental disease are not being treated in the Hospitals. In the last Annual report, published by the Inspector of Hospitals for the Insane, we find that 1337 new cases were admitted during the year. You will see from this that the medical practitioners in the Province of Ontario had during the year to decide on the mental condition of those 1,337 cases, and they probably also had as many cases whom they knew were suffering from mental disease, but because of the character of the illness and the circumstances at home, the Doctor considered that they could be treated just as well at home.

This is a big responsibility laid on the physicians of the Province, and I wish to-day to draw the attention of the members of this Association to what we in the Hospitals

for the Insane may do to help in this work, and at the same time to ask that your help may be given to us.

In the first place, when you send a patient to the Hospital for the Insane for treatment, we can guarantee to you to-day that he will be given good and scientific treatment. He will be treated carefully and kindly; records of his case will be kept, probably more completely than in any other kind of a Hospital. All cases that come will be placed under the care of a trained female nurse. The Ontario Government has established a training school for nurses in our Hospitals. The course of study and lectures are at least equal to that of any other hospital. It is a three year course, and to those of our graduates who are suitable for positions of trust, we arrange for a post graduate course. All our nurses in the Toronto Hospital for the Insane are either graduates or undergraduates. We have at the present time sixteen nurses who have graduated from our own school, and who have taken the post graduate course, and this year we have forty-five nurses taking the various examinations of the different years, and added to this a probationary class of about twenty. I draw attention to this fact, because away back in the dark ages the impression was prevalent that patients in the asylums were treated harshly and sometimes abused. The public mind seems to retain this impression, and I know many people yet, who think that when a patient is admitted to the hospital for the insane, that he need hope for nothing in the way of sympathy or kindness. In fact we often receive applications for nurses, both male and female, in which the applicant states that he or she is strong and able to defend himself or herself from the attacks of the patients. At the present time restraint of any patient in a hospital in Ontario is prohibited by law. Straight jackets, muffs, straps, restraining sheets and so forth are never used. Every male patient that comes into the Toronto Hospital for the Insane is sent to a ward and placed in the care of

female nurses. There is no exception to this rule, and we have not found a case in the last three years that women could not manage. There is no need for abuse, for force or for harshness. Our patients are the same as other people. When treated kindly and reasonably they respond to that treatment.

Concerning the medical care of the patients, I can say that the Department of our Government that controls our Hospitals has encouraged us in every way. We have well-equipped laboratories in each Hospital. We do our own Wassermann's, our own Widal's and the various tubercular tests. In short, we do all the ordinary laboratory work that is done anywhere in the country. Records of this work are kept on file. When a patient comes to us we try to get the family history and the personal history. We try to find out everything about him; what he has been from his birth; how he developed when a child; how he got along at school and how he got along at his various occupations. We try to form an estimate of his character previous to his mental illness. We then make an attempt to sum up his present mental condition, and in this way we measure the amount of change that has occurred in that man's mental health. These records are kept, and day by day new notes are made. During the first few weeks of his residence, or possibly for months, the patient is kept in bed, and complete charts are kept by the nurses. In these charts notes are made of the usual items, such as temperature, pulse and respiration; the movements of the bowels, amount of urine, etc. Also the exact amount of diet that he takes, and how he takes it; his conversation, and any peculiar actions such as twitchings and grimaces, his conduct towards the other patients and towards the nurses. After these charts have been kept for a period of some weeks it is a comparatively easy matter for anyone to go over his case and decide what is best to do with this man. There was a time when it was thought that if a man was once admitted to the asylum,

this was his end; he never came out again. At the present time we believe that idea is wrong. During the past year we discharged from the Hospitals for the Insane in Ontario 612. These 612 people went home under the care of the family physician again. If you will consider for one moment that each year six or seven hundred people are going out of the Hospitals for the Insane into this Province you will see that there are several thousand people now taking care of themselves, and getting along in the outside world, who were at one time resident in the Hospitals for the Insane. The duty now devolves upon the medical men of this country to arrange for the admission of 1,500 people and also to direct the home care and treatment of six or seven hundred additional cases each year who have been discharged. We can help in this care by facilitating the admission of patients to the Hospitals for the Insane. This we attempt to do, but as this is a legal matter there are certain forms that must always be complied with. We can help you by taking in patients in the same way that they come to other hospitals. The law of Ontario arranges that we may take a voluntary patient.

Nearly any case of mental disease, if taken early enough, will come by himself to the hospital asking for treatment. We get a great many cases of this kind now, and we try to encourage this form of admission, because we can do more for the patient who gives us his confidence than we can for the patient who is compelled to come to us, and who feels that he is being unjustly treated in being detained in the hospital. We can also help you by giving you the results of our investigations. It seems to me that it would be a great help to us, to you, and chiefly to the patient, if the Hospital physician and the family physician would only work together. We could furnish you with the results of our laboratory findings, with the psychic analysis, with a report on the con-

duct of the patient while in the hospital. We could consult with the family physician before the patient is sent home, and have his home surroundings arranged for him.

Many times a patient discharged from the hospital has to return at once, because the people at home do not know how to receive him, how to treat him, or because the conditions at his home are so incompatible with his mental condition, that it is impossible for him to stay there.

Now I have promised that we can give the patients sane, scientific and sympathetic treatment, and in addition we can do three things for you.

(1) Give the privilege of voluntary admission.

(2) Where this is not practicable we can facilitate the admission of suitable patients by getting in touch on the telephone.

(3) We can give the doctor the results of our study of the case in return for the help he has given us by sending a complete history of the case.

But there are some things that we would ask from the family doctor in return.

1. That the case should come to the hospital early. It is a most hopeless condition when the patient comes along with a history of having been peculiar for the last four, five or six years. In the Manic Depressive cases, if they come early the attack can often be aborted. In cases of Exhaustion Psychoses, if the patient comes early, his life may be saved, and I think I am safe in saying that 99 per cent. of the Exhaustion cases if treated outside the regular hospital for the insane will die within two weeks. In cases of Dementia Praecox, the early treatment is the only treatment that is any good. After the psychosis is well established the personality is changed and it is just as impossible to restore him to his normal condition as it would be to change a Chinaman into a Negro. The symptoms of Dementia Praecox are plain and easy, and if

recognized early the man may be restored in a certain degree.

2. You may also give us a full history of the case. It is important that we should get an exact idea of the kind of people his mother and father are, their peculiarities, how they live, their view of life, if this child is the same as the other brothers and sisters, if he was as bright at school as the rest, or if he was always a little peculiar, what changes were first noticed and what were the first changes in his disposition. The diagnosis of a case depends upon how the case developed. The end stages of all forms of mental disease are pretty much the same. In seniles we get dementia, in paresis we get dementia. The end stage of dementia praecox is dementia. The epileptic will finally show all the symptoms of dementia, and when this condition develops in any form of mental disease, it is hard for us to either diagnose a case, or to do anything for it.

3. The doctor can also educate the public and the friends that the patient will be taken care of in the hospital, that he is sent there because he can be better taken care of there than he can be at home. He can explain to the friends that the people in the hospital for the insane are human beings and not monsters, that they do not punish and persecute the patients.

4. You can help us again in discharging patients into the care of their friends by keeping track of them, by letting us know how they are getting along, by reporting if the home conditions are suitable and congenial. It will certainly help the patient to know that somebody is taking an interest in his welfare.

5. You can help us if you will do all in your power to discourage the use of the words: "crazy, lunatic and asylum." These words seem to carry with them the echo of the dark ages. They all have unpleasant associations, they are unnecessary, and it is just as easy to speak of a

sick man or of a hospital and not try to differentiate between the respectability of one form of illness and that of another.

Unfortunately there is an idea prevalent that it is a horrible disgrace to have a member of your family treated for mental symptoms. The friends and even the doctor will come along and say, "I think it is just his nerves, just a nervous breakdown, I don't think he is crazy." I cannot see where it is any disgrace for an old man or an old woman to lose their memory, to become clouded, confused and restless. I cannot see why anyone should blush because a poor woman when working hard, raising a small family, trying to keep house and doing work enough for three or four people, should break down, become exhausted and show signs of delirium. Her secretory and excretory organs are all deranged and her condition is a simple matter of physiology. Other forms of mental disease are the same. Teach the people that the hospitals are for the care and treatment of these people, that the original purpose is to try to cure disease, that the hospitals are not the places of confinement. Remember that when the rich man becomes worried, feels himself failing, or becomes exhausted, he is recommended to take an ocean voyage; to go to Musoka for the summer or to Clifton Springs. He has all sorts of sanitariums and summer resorts at his disposal, but think of the poor man's wife who is overworked to a much greater degree and who has nowhere to get away from the strain and worry and anxiety that are attacking her, and who has no bright spot in the future, and upon whom the cloud of despondency is settling; when she breaks down what do you advise her to do? Our ideal is that we shall have a voluntary admission system, that our hospitals shall be the poor man's sanitarium, that we shall get the incipient cases, that we shall gain the confidence of the people, and in this way be of more use to them.

We want the people of this province to know that we have Hospitals supported and maintained in which the over-worked, the worried, the confused and the despondent will always find rest and relief.

We want them to understand that the hospitals are maintained by themselves, that in these hospitals they will always find sympathy and encouragement. That they will always find abundance of rest, sleep, sunshine, milk and eggs, for after all these are the basis of the treatment of all forms of nervous and mental diseases.

In closing I want to draw attention to an experiment that has been made in Toronto. We have the use of one building of the old General Hospital group, and in that building we can accommodate forty-five patients. We call this the "Reception Hospital." It is used for the reception and observation of incipient and suspected cases of mental disease. Anyone who has a case that has given him worry may send his patient there without being certified to as insane. In fact we have a great many voluntary patients, and many who come tell us that if they had only known of this place they would have come here long ago. In some cases a mother brings her daughter for treatment, or a man may bring his brother. The Hospitals send us many cases, and the police bring along those whom they pick up on the street and whom they suspect of some mental peculiarity. These people come to our place; remain for periods varying from one week to two months, then we are in a position to advise them as to what should be done. If a case is well developed or an old case of mental disease, we send him on to a regular hospital for the insane. Although we have accommodation for only forty-five patients, still in ten months we have admitted 466, and of this number 168 have been sent on up to Queen Street Hospital for the Insane. We have at present in residence 45 patients, so you see that there must have been a balance of 255 people discharged.

This little hospital has proven a great help to us, as it

enables us to get in touch with a great many early cases. We can study them and advise the friends as to what should be done. Our greatest difficulty is, that an attempt is being made to fill us up with Morphia cases, alcoholics, feeble-minded children, and with many young men from good families who have got into the Police Court for various troubles. Naturally their friends are quite convinced that the boy who has forged a note should go to a Hospital and that there must be something wrong with his mental condition. We believe that this Hospital is the beginning of a real up-to-date Psychiatric Clinic, where all classes of mental illness will be taken in, studied scientifically, given benefit of the best medical aid, and we hope to make our present little hospital so successful that before long other Reception Hospitals or Psychiatric Clinics will be opened in the various centres of the Province.

THE FEEBLE-MINDED.

By J. P. Downey,

Superintendent Hospital for Feeble-Minded, Orillia, Ont.

The space allotted to the Hospital for Feeble-Minded in this number of the Bulletin may be profitably occupied by a reference to some difficulties and misunderstandings in the work of our Institution. To the public and to those charged with the management of the Hospital an ever-present problem is the pressure for accommodation. Repeated requests for the admission of a case, always met with the same response, "No room," seem to convey in some quarters the impression that we are not trying to do our full duty. A few facts should relieve the minds of those interested of any misapprehension in this regard. In the first place it should be remembered that our population is different from that of a Hospital for the Insane. We do not pretend to cure cases of mental defectiveness. All we can do is to develop as far as possible the mentality of the children sent to us, increase their interest in life and make them more useful and a source of some help to the Institution charged with their maintenance and protection. Unlike the Hospitals for the Insane, there is little movement in our population. From the Hospitals for the Insane a great many are discharged annually as cured or improved. Four of them in 1913 discharged ten per cent. of their daily average population. In the same year our population was 815 and our discharges three, or less than one-half of one per cent. With us it will be seen the number of vacancies in any year depends largely on the number of deaths. If the death rate is low the admissions are few.

Let us now see how the Hospital for Feeble-Minded has tried to meet the public demand for the reception of the mental defectives of Ontario during the past few years. The normal capacity of this Institution is placed at 740. For the year 1912 our daily average population was 814; for 1913, 815; 1914, 815. These figures would indicate that we are keeping the population up to the very limits of our accommodation and that the crowding in of more cases is impossible if we are to have any regard for the health and comfort of our patients.

The building operations now in progress will mean substantial and welcome relief. When the two cottages in course of erection are completed we shall be able to open our doors to probably 300 more patients. Meanwhile the parents of children who should be here and the medical men of the Province interested in feeble-minded cases will, we hope, exercise the virtue of patience.

Proceeding, let us emphasize one or two points that the public appear occasionally to lose sight of. First, this is, as its name denotes, a hospital for feeble-minded. Now and then we have parents and physicians seeking admission for a child whom they say is not mentally defective. We have had physicians erase the declaration of the child's defectiveness from the certificate, and thus leave the certificate as valueless as a blank sheet of paper. If the person for whom admission is being sought is neither imbecile nor idiotic the Hospital for Feeble-Minded has no right to receive the case. We are not conducting a school for dull or backward children. Ours is a training school and custodial institution for children who are not normal and never will be normal.

I wish I could indelibly impress on the minds of the people those two words "for children." Many times we are urged to make room for old men and old women. Imbeciles they are, no doubt, but harmless, inoffensive bodies who would be quite comfortable and could be easily taken care of in any House of Industry. Every

harmless patient of that type admitted to this Institution is a denial to another case of treatment and protection gravely necessary in the interests of the unfortunate and society as well. To train and protect the children—that is the first and all-important purpose of this Hospital. It is only natural, I suppose, that each municipality should strive to unload as many as possible of its charges upon the Province, and were there room for all, this shifting of the burden of maintenance would not be so serious a matter. But when, as is the case, there are two boys or girls sorely needing training and protection for every vacancy that occurs, it is unreasonable to expect that we should open our doors to harmless old men and women whose only trouble is they have no one to look after them.

Working for the reduction of the mental defectives as a class our only hope of success lies in the identification and segregation of all feeble-minded children, young men and women. This is a rational application of the science of eugenics. It places one class of the unfit humanely and comfortably in positions where they cannot marry or reproduce their kind. And, by the way, it is only in an institution such as ours that the defective girl or young woman is absolutely safe. The private home that affords her adequate protection must make a virtual prisoner of the girl and deny her pleasures which under proper surveillance she is privileged to enjoy in an institution.

This, then, should be the aim of all those who desire to help in the work among the feeble-minded: To mark for institutional control the cases that in their age and character present the greatest danger of reproduction. The boy may be able to run errands and do unskilled work; the girl may give promise of developing usefulness in household duties. These facts may intensify, they certainly do not lessen, the dangers of marriage, or the graver evil which spells misery for the unfortunates and a heavier burden for the State. And yet many people think

the only feeble-minded who should be sent to our hospital are the feeble-minded who cannot do anything. We are often asked: "What is that girl doing with you? She can work." The tragedy of the situation is that in many private homes in the Province the feeble-minded girl knows only work and the monotonous seclusion that hides the shame of her proud sisters.

From what I have already said it is quite obvious that the policy that makes for the most generous and most effective segregation of the feeble-minded is the policy that will achieve the greatest measure of success. We cannot bring ourselves to seriously consider any other remedy. Sterilization, even if it could be justified on humane and moral grounds, has not, where adopted, fulfilled the expectations of its advocates. Some earnest, well-meaning people urge the erection of schools which shall train and care for the feeble-minded until they reach maturity. That proposal merely carries the mental defective to the edge of the danger zone. The gravest necessity for their institutional oversight would present itself when the school had finished its work. Indeed, the training of the school may have improved the manner and appearance of the girl or boy and rendered matrimony or its worse alternative all the more easy. The school for feeble-minded must therefore provide a home for its graduates, and the measure of the accommodation of that home will be the measure of the service the school will perform. I was recently told of a case in one of the bordering states. A feeble-minded boy made gratifying progress in the training-school, became an efficient member of the band and a valued assistant in the carpenter shop. The school had done all for him that any school could be expected to do. This boy eloped from the institution, married a former nurse, and the two children that have been born of the union are defective.

The solution of the problem of the feeble-minded cannot, therefore, be reached through the building of schools,

invaluable though they be for the development of the usefulness of this unfortunate class. When the children have finished their schooling, what then? Are they to be sent back to their homes or set loose in the world? Or shall there be another set of institutions to receive and protect and utilize the labor of the graduates of the schools? For my own part I am firmly of the opinion that an institution such as ours—training-school and home combined—meets the requirements of the situation more effectively and more economically than any other plan so far suggested. In our report for the year ending October 31st, 1912, we dealt with this phase of the question at some length, and the views we then set forth we have reason to emphasize now!

"To my mind the ideal institution for the feeble-minded is one that opens its doors to all grades, provides for their proper classification, and, while ministering to the comfort and happiness of all, develops in the improvable cases the greatest usefulness of each. The helpfulness and sympathy of the rugged and healthy toward their stricken companions have impressed me more than I can tell. Nowhere, I believe, can one see more worthy examples of self-sacrifice and true Christian charity than among these children, feeble in intellect, 'tis true, but strong in the generous impulses of their hearts. In an exclusive training-school, where the service would be entirely dependent upon employees, opportunities for the development of the virtues to which I have referred would be fewer, and the spirit of mutual helpfulness less pronounced.

"But the economic side of the question cannot be ignored. The maintenance of this and kindred institutions is kept well within the financial resources of the Province by the labor of the patients. Were we to stop the work of our men in the fields and barns and shops; of our girls in the sewing-room, laundry and wards; and engage outside help for these various services, the annual

expenditure would be enormously increased. If, then, the Province and the municipalities have to care for the feeble-minded, the greatest service to that unfortunate class with the lightest burdens on the people would, in my opinion, be rendered, not by building and maintaining a separate training-school for high grades, but by developing the system under which the improvable cases can be trained according to their capacity, workers can be given healthful, productive employment, and at the same time the comfort of the helpless ones sympathetically ministered to. With adequate accommodation, perfect classification of the various grades is easily attainable under such a system. Indeed, I rather incline to the belief that a more efficient training-school is possible in the presence of the larger operations and more varied activities of an institution such as ours than in a training-school set apart as such and devoted solely to the education of high grades."

We have been considering in this article the case of mental defectives. The dull or backward child presents another problem and one for the educationist to solve.

LA GRIPPE AND SOME AFTER AFFECTIONS

By Dr. J. J. Williams,

Medical Superintendent, Hospital for Epileptics, Woodstock, Ont.

In August, 1913, we had quite a number of our patients afflicted with La Grippe which was of a severe type, the symptoms being hard to control, temperature unusually high in most cases. All but five made a complete recovery, that is, without after effects. We had no deaths resulting from this epidemic, but we had a peculiar and prolonged after-effect which was very marked in each of the following cases:

Case 1.—Young man 25 years old, physical health good, mentally fairly bright, has had epilepsy for fifteen years, frequency of attacks, two per week. Family history good. He is slow of speech and somewhat melancholy. He developed La Grippe in August, 1913. Towards end of attack he lost complete power of legs. Had marked neuritis in the soles of feet, flexure of legs at the knees, some atrophy of extensor muscles. Treatment adopted—electricity, massage and tonics, and several times under the influence of chloroform the limbs were straightened as far as possible. The above treatment was carried out steadily for ten months, when the patient was able to use the limbs and commence to walk a little. Present condition: after a period of twenty-one months there is still quite a marked flexion at the knee joints. Outside of this he remains about the same as he was previous to attack of La Grippe.

Case 2.—Young man 18 years old, with a weak, rapid heart, mentally feeble-minded, been an epileptic for seven years. Family history good. Developed La Grippe in

August, 1913, symptoms severe, lost complete control of legs, marked neuritis of soles of feet, muscles of arms weakened, power almost gone. Treated with electricity, massage and tonics. Five months elapsed before complete use of limbs was restored and recovery from this trouble was complete.

Case 3.—A young woman 25 years old, nervous temperament, very excitable, has a rapid heart, rarely under 115 per minute. Epilepsy began at the age of six years, attacks frequent, averaging twenty per week. Father of patient was an epileptic; history of neurotic trouble all through the family. This girl developed La Grippe in August, 1913; after effects were complete loss of power of legs, extreme neuritis of soles of feet, marked atrophy of extensor muscles of legs. After treatment for nerve affection consisted of electricity, massage and tonics, resulting in complete recovery of function of limbs. All symptoms abated at the end of six months' treatment.

Case 4.—An elderly woman 68 years old, physical health good, mentally fairly bright, has had epilepsy since childhood. Family history good. Seizures average about two per week, of Grand Mal type. In August, 1913, she developed La Grippe lasting a few days, when symptoms abated. About this time severe nervous symptoms set in, there was complete loss of power in legs and arms, marked neuritis in soles of feet and palms of hands. All control of sphincters lost, patient became emaciated and experienced some difficulty in talking. Heart's action became irregular. Treatment consisted of electricity, massage and general tonics resulting in a complete recovery at the end of seven months.

Case 5.—Young woman, age 30, good physical health, mentally dull, has had epilepsy for sixteen years, which is inherited. Seizures occur about two per week. In August, 1913, she developed La Grippe, all symptoms being severe, leaving as after effects complete loss of power of legs and partial loss of use of arms, neuritis

being quite marked in soles of feet; speech somewhat affected; patient became very much emaciated. The treatment consisted of electricity, massage and tonics, resulting in a complete recovery at end of four months.

These five cases were watched closely and a careful record made of their seizures during this illness, and we found there was no diminution nor increase in the number of attacks, epilepsy running its usual course. The above were the only patients that exhibited these peculiar and obstinate after effects, although many of the others afflicted by this epidemic had symptoms equally as severe as any of the five cases cited.

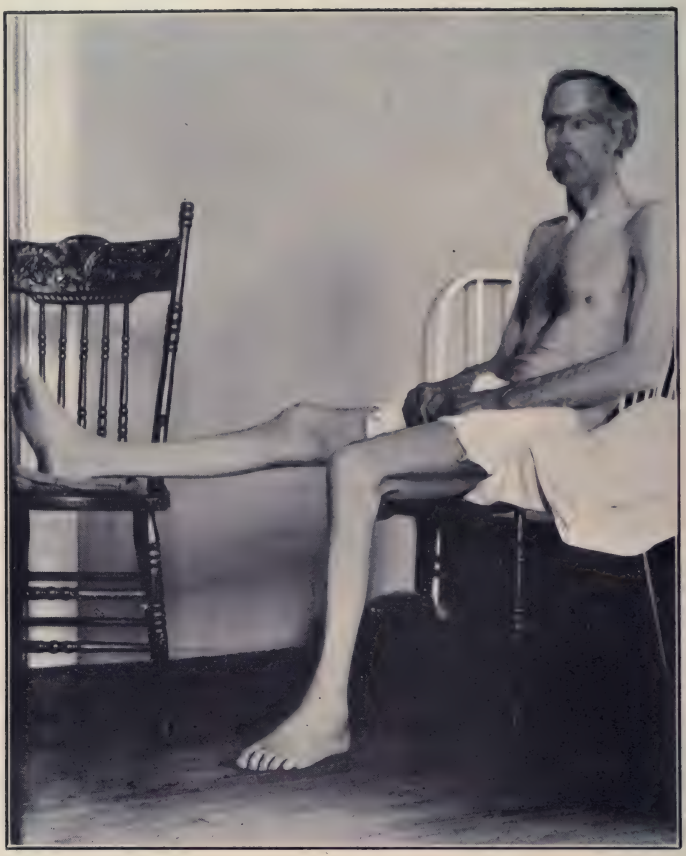

Fig. 1.—Shows the contrast in the muscular development of the leg and thigh muscles.

REPORT OF A CASE OF THE PERONEAL TYPE OF PROGRESSIVE MUSCULAR ATROPHY.

By A. McCausland, M.D.

Hospital for Insane, London.

This case is reported not because of its mental but because of its neurological interest. The only mental symptoms are those of irritability verging on a hypochondriacal condition. Dr. McCallum and Dr. McGregor at our request saw the patient and confirmed our diagnosis.

Family History.

His father died at the age of fifty-two of cholera and his mother of cancer, the situation of which was unknown. Two brothers are living, one of whom is sixty-seven years of age and is crippled with Chronic Arthritis. He has one sister living and three dead. One died of diphtheria and the other two of cancer. He has one son who is of low mentality.

Personal History.

Patient is a Canadian farmer, sixty-nine years of age, who was admitted to the Hospital for Insane on May 14, 1915. His birth and early life were normal. His education was very poor, having received only about five months' schooling. He has always been a very hard working man of temperate habits. He used tobacco only moderately and never used alcohol excessively. His past illnesses were typhoid fever when he was eighteen years, from which he made an uneventful recovery, and a mild

form of Icterus one year ago from which he has never fully recovered. He denies any venereal disease.

Present Illness.

The onset of symptoms first appeared over nine years ago. When doing extra hard work he was seized with a severe pain in the left Hypochondriac region, which he has complained of being painful and pulsating ever since. This pain later extended to the hip and continued for over a year, when pain developed in the great toe, succeeded by numbness and gradually increasing atrophy and weakness of the legs. The pain was excruciating. With the onset of the numbness, the pain subsided. The numbness first began in the big toe, then in the ankles and then gradually extended upwards. Six months after the onset of symptoms in the left leg, a similar condition began in the right. He has been unable to work or to attend to his affairs for the past two years.

Physical Examination.

General—Patient is very poorly nourished. There is marked bilateral atrophy of the lower extremities from the knee downward. The shin bones are very prominent. The muscles of the calves of the leg are very much atrophied. There is a marked contrast in the muscular development of the leg and thigh. There is considerable wasting of the Vastus Internus on the right leg. Fibrillary contractions are present over both Vastus Interni, the tendons of the Hamstrings and over the remnants of the wasted muscles. The feet fall in walking, giving him the steppage gait. He has a characteristic claw-foot. He is unable to stand or walk without the assistance of a cane. The trophic changes in the skin are not marked. The hairs are well nourished and of normal appearance. The hands reveal slight atrophy of the thenar and hypo thenar

Fig. 2.—Shows the wasting of the leg muscles; the atrohy of the right Vastus Internus is seen to be more marked. The claw foot is seen in the right foot.

eminences and quite marked atrophy of the interossei muscles. There is a paraesthesia of the hands. For the past few months he has complained of a numbness. He describes the sensation similar to that after a scalding. He has not the characteristic claw-hand, but the little fingers of either hand show ulnar deviation with hyper-extension of the proximal and flexion of the two distal phalanges. Both scapulae are somewhat prominent.

Respiratory System.

Inspection.—Chest measures on expiration thirty-seven inches and on inspiration thirty-seven and three-quarter inches. The clavicles are very prominent. The supra and infra clavicular fossa very deep.

Palpation.—Vocal fremitus and resonance is very slight. The movements of the chest are shallow.

Percussion.—The apex of both upper and lower lobes yields a slightly duller note than normal lung tissue. The superficial area of cardiac dullness is absent owing to the emphysematous condition of the lungs. The lower lobes yield a hyper-resonant note.

Auscultation.—Vocal resonance is decreased over the front of the chest but quite normal posteriorly. The breath sounds are normal. No rales audible.

Cardio-Vascular System.

The Pulse.—The rate of the pulse is 60, regular in rate and rhythm. The vessel wall is slightly palpable. The volume is good but poorly maintained. The vessels in the axilla and at the elbow pulsate. The pulse approaches the water hammer type very closely.

The Heart.—The apex beat is invisible and not palpable. There are no adventitious heart sounds, but the sounds are faint, due to the emphysema present.

The Digestive System.

Subjective History.—Appetite fairly good and patient able to take quite a good amount of nourishment each day.

Physical Examination.—Teeth in fairly good condition. The tongue and mucous membrane moist and clean.

On abdominal inspection and palpation nothing abnormal detected. On percussion the lower edge of the liver was found to be one inch below the costal margin.

The Genito-Urinary System.

Normal.

Cerebral Nervous System.

First Cranial Nerve.—Patient unable to smell.

Second Cranial Nerve.—The left eye revealed a cataract, but daylight and dark could be distinguished. The pupil re-acted normally.

The right eye was found to be defective, patient being unable to read without very strong glasses. Pupil very sluggish to light and accommodation.

The other cranial nerves found to be normal.

The Reflexes.—The knee and ankle jerks were absent. There was no Babinski or Ankle Clonus. The Cremasteric reflexes normal. The abdominal reflex elicited only over the left side of the abdomen. Rhombergism present.

The Sensorial Motor Nerves.—The legs are very weak and there is inability to walk well or to stand. He is easily fatigued. Fairly good power present in the arms.

Sensory Nerves.—Sensation of heat and cold is retained. Tactile sensation is slightly diminished, although orientation of the area of stimulation is delayed.

Fig. 3.—This shows the posterior view. The right Vastus Internus is seen to be quite atrophied.

Laboratory Work.

A Wasserman was done which was found to be negative. The Blood Examination revealed 5,600,000 reds, 7,000 whites, with Hemoglobin 80 per cent. The urinalysis showed the urine, Acid, Specific Gravity, 1020. No albumin, no sugar, but Bile Pigments quite abundant.

Discussion.

The Peroneal type of Progressive Muscular Atrophy generally occurs in young persons before the age of twenty. As has been remarked before, the above patient is sixty-nine years of age. The history in this case presents no hereditary disposition, nor no history of any infectious disease previous to the onset of the trouble. It is of interest to note the continuous pain and atrophy of the legs began some nine years previous to the allied symptoms occurring in the hand. The symptoms appear to be typical of the Peroneal type of Progressive Muscular Atrophy described by Tooth, Marie, and Charcot. It is said to be an extremely rare form of disease. The comparative slight wasting of the thigh muscles, the marked atrophy of the leg muscles, and the beginning pain and atrophy of the hands, are against the diagnosis of double sciatica. The muscular atrophy, the absent deep reflexes, the fibrillary movements, are indicative of a lower neurone lesion. As there are no trophic changes in the skin of the legs, we are doubtful of the origin as being neuritic. Condition is suggestive of a Chronic Anterior Poliomyelitis in which condition the cells of the Anterior Cornua undergo slow degeneration. There also occurs a degeneration of the posterior columns. As the symptoms in this case are mostly motor, with little sensory involvement, leads us to believe the changes are chiefly in the Anterior Cornua.

TYPES OF HOSPITAL CASES.

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Neurological manifestations not uncommonly accompany mental disease and it would appear that such manifestations are associated factors and not directly causal of the mental disorder, possibly they are independent of it altogether. Although almost every form of nervous disease may be found amongst the insane, those of most common occurrence are epilepsy, general paresis, hemiplegia, huntington's chorea, syringomyelia, and pellagara, these being arranged in order of their most common occurrence.

One in every fifteen of the patients at the Mimico Hospital suffers from epilepsy. A very small percentage would cover general paresis in spite of the fact of other institutions having a large number of such cases. Hemiplegia, from whatever cause, is of rare occurrence, less than one per cent. of our patients showing symptoms of such a lesion. Syringomyelia and huntington's chorea are still less common. Pellagara is occasionally seen, several cases having been already reported in other issues of this journal. The clinical examination of the following cases may be of interest to the reader:—

Case 1 :—W. A. F., dementia praecox of the catatonic type; aged 42 years, lies in bed on his right side with mouth wide open, limbs drawn up and in a spastic condition. In spite of the emaciated appearance he takes food voluntarily and satisfactorily. He will not respond to questions asked him and appears oblivious to his surroundings. His head presents a peculiar appearance in view of its large size and absence of hair over

large areas. The cheek bones are large and the lips hypertrophied, particularly the upper lip. The abdomen is retracted and the bones of the lower costal margin prominent. The iliae stand out in marked relief in the lower abdominal region. Muscular atrophy is progressing over the body and is particularly marked in the upper limbs, but not to such an extent in the lower limbs. Over various portions of the body, viz., buttocks, knees, elbows, dorsal surface of the feet, there is destruction of tissue which is supposedly due to burns sustained by coming into too close contact with the radiator. Anaesthesia is disassociated. Sensation to pain, heat and cold is gone, while the faintest tactile sensation is retained, the slightest touch to the plantar surface of the foot causing a clonic contraction over the body. Reflexes are markedly exaggerated. Sustained ankle clonus with a Babinsky is also present.

Summary:—Trophic changes, disassociated anaesthesia, progressive muscular atrophy together with signs of an upper neuron lesion.

Case 2:—E.K., imbecile; aged fifty-eight, thin, poorly nourished, yellow pigment over body. There is motor restlessness of all the voluntary muscles, particularly of the limbs of the lower extremities. The gait is a peculiar one, the body sways, she takes several ataxic steps quickly, then stands and grasps for something to hold. There is a slight limp particularly in the left leg on which side there is a dragging movement of the toes when walking. Standing, there is a rocking movement of the trunk and it is necessary for her to hold on to some object or spread her limbs widely apart in order to keep from falling. While sitting, she is restless, all voluntary muscles acting. Movements of lower extremities will be increased if she carries out any definite acts of the upper limbs. She makes grimaces and gesticulates. The motor restlessness is becoming more marked. At first she had power to suppress movements to some extent by the

execution of such voluntary acts as reading, writing and other delicate work, but at present she cannot hold a lead pencil to write. Reflexes are markedly increased. There is a Rhomberg sign present. Alteration in the voice, which is high pitched, is also presented in this case. She talks a great deal, cutting her words short. Her mental condition is one of progressing enfeeblement. She does not work, is irritable, resistive and difficult to manage.

Summary:—Motor restlessness of muscles under voluntary control affected, ataxia, mental weakness progressing.

Case 3:—M.G., dementia praecox of the catatonic type, age 28 years. Chart showed nothing of a serious change in temperature, pulse or respirations, but the bowels moved frequently and soon she became involuntary. She looked extremely sick and said that she felt very ill. This was the first she had talked for a long time. Her taking to bed was not characterized by an elevation of temperature or rigors, but she was extremely tired and depressed. At times she was seen to vomit, although she would eat well, and sometimes have attacks of vomiting. Until her having to remain in bed she appeared to be happy, and, although mentally confused and with no realization of her condition, she would laugh and walk about. This tired feeling was noticed after she had been vomiting a few times. It was hard for her to lift her arms. Her legs did not seem to give the support to her body that they previously gave and in place of standing up and walking around as she formerly was accustomed to she would sit down instead. For some time she has been subject to what was thought to be attacks of tonsilitis but she would recover from this. These attacks gave place to a burning sensation in the throat which she described as being hot; this has been growing worse, causing her to ask for a drink of cold water every few minutes. She apparently had no difficulty in swallowing but her

throat was dry. The tongue was so swollen and sore that she was unable to protrude it. Her lips also were swollen to some extent and at the angles of the lips the skin was cracked and they bled considerably. She complained of headache, pains in the back which she could not locate, and also in various joints, which she described as being "all over her." These symptoms have been developing since her going to bed and reached their maximum the third day. The temperature ascended to 104 degrees, pulse 150, and respirations fast. She was voiding urine and faeces involuntarily nearly all the time. Extreme sensation of heat was felt and she expressed a desire to see her mother, although when her mother came it is doubtful if she recognized her. The eyelids would droop and be closed for several seconds, then twitch and regain their normal condition. There was no rigidity of the pupils and her vision seemed undisturbed. If she would take more than a sip of water, she would vomit it and attacks of pyrosis were present nearly all the time. For the last three days the main gastro-intestinal symptoms were anorexia, nausea and vomiting with pyrosis and also profound obstinate diarrhoea. The erythema, which while she was out in the sun was shining and hyperemic, became dark in color, cracked and desquamated and at no time has it become hyperemic like it was seen to be when she was with the other patients enjoying the walks in the morning. Her forehead was slightly blotched, the desquamation consisting of small copper-colored scales. Over her eyes and extending for a short distance on the centre of the nose the copper colored rash was only slightly apparent. On the lower jaw also there was a scaly eruption. On her neck there was a symmetric-erythema which started in the middle line and extended back on both sides to about as far as the posterior border of the sterno-mastoid muscle. It was about one inch in width and tapered slightly until it reached its extremity, where it was about one-half inch,

being wider in the middle line. On the dorsal surface of her hands a copper colored erythema was also present, being more marked on her right hand and extending there from the tip of the fingers to well up on to the back of the forearm, terminating there in a point in the shape of an inverted "V". The eruption on the left hand did not extend much above the base of the fingers and the hands were pigmented, slightly swollen and rough but at every place where the eruption was seen it disappeared on pressure. The skin on the back of the right hand was inelastic and slightly atrophic. The nails were brittle, knee jerk slightly increased and an intentional tremor observed when taking water from a glass. Her sleep became bad, although her mental condition has been improving somewhat. Although she formerly had a loss of sense of place, when asked what this place was she said it was Mimico. Memory slightly improved. She complained very much about her body having a burning sensation. Her talk was slow and it seemed difficult for her to articulate, not only from the hypertrophy of the tongue and extreme salivation, but she became markedly retarded. Three days after going to bed she died in a typhoidal condition.

Summary:—Cachexia, intoxication, Gastro-intestinal disturbances, cutaneous symptoms, motor and psychical phenomena.

Fig. 1.—Tumor before operation.

UNILATERAL ENLARGEMENT OF THE THYROID GLAND OF THE VASCULAR TYPE.

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THE patient C. H. was admitted to this Institution on April 15th, 1910, having been transferred from Mimico Hospital for the Insane, where he had been a patient since March, 1880. The parental history is unobtainable and the personal history presents little of interest as regards the case to be illustrated.

He was born in the year 1854 and was at the time of operation 60 years of age. At the age of 26 he suffered from a severe mental attack characterised by deep melancholia with delusions of a religious nature. The cause is attributed to the excessive use of liquor and the indolent and careless manner of living. Since becoming a patient here he has always conducted himself quite nicely, giving little trouble to those in attendance, but at all times in need of careful surveillance and often times requiring tube feeding. His obedience to the calls of nature was such as to necessitate frequent changes of bed linen and clothing.

Of late he has become very untidy about his personal appearance and more filthy in his habits, also restless and somewhat destructive. His peculiar habit was that of tearing up newspapers into pieces about the size and shape of paper bills and of which he was very careful to see that none were lost or stolen.

On admission his physical condition was quite robust. At that time there was a good sized tumor occupying that area just above the Clavicle on the right side, which is nicely illustrated in the accompanying picture (Number

1). This tumor became somewhat enlarged during the intervening years between the time of his admission and the time of the operation some years later.

Pressure symptoms on the Recurrent Laryngeal Nerve and Trachea with accompanying Dyspnoea necessitated operation, the chances of which had often been considered, but on account of the immensity of the task this was delayed.

On October 15th, 1914, the patient was admitted to the Solarium and the necessary steps preceding the surgical treatment were taken. The field of operation was shaved and Tincture of Iodine B.P. strength applied each day for three successive days. Hypodermics of Morphia, grains 1-4 were given each morning in hope of allaying shock during and following the operation. On the 18th, the patient was removed to the operating room and given a general anaesthetic by Doctor J. C. Mitchell; Doctors F. S. Vrooman and C. D. Hamilton assisting at the operation. Extirpation of the affected lobe was the object in view.

A transverse crescentic incision was made extending from the posterior border of the right Sterno-mastoid muscle at the junction of its upper and middle thirds in a downward direction across the front of the neck to the middle of the anterior triangle on the opposite side. The skin and Platysma Myoides being turned upwards, the Sterno-hyoid, Sterno-thyroid and Omo-hyoid muscles were exposed to view. The external jugular vein was found to be displaced by the right border of the growth.

The other muscles were strongly retracted to the median line and the fibrous capsule of the tumor divided transversely. This was found to be loosely adherent to the surface of the Vascular Goitre, and blood vessels passing from the gland to the Capsule were tied with double ligatures of number 1 plain cat-gut.

The tumor presented a glistening appearance upon whose surface were innumerable arteries and veins. On

pulling downward on a Vulsellum which was attached to the most prominent portion of the growth the attachments of the tumor posteriorly were brought to view. These were of the nature of dense connective tissue and quite firmly united the growth to the Larynx and Trachea and even extended along the anterior surface of the sheath of the Carotid for a considerable distance.

The lower portion of the lobe was dissected below the Sterno-clavicular joint and its removal therefrom although not impossible would have rendered the operation much more serious. The superior Thyroidal blood vessels were sought for and found to enter the tumor on its superior and medial aspects. These were doubly tied with number 3 ten day Chromic Cat-gut Ligatures.

After turning the tumor to the left the inferior Thyroidal vessels were treated in like manner. Here, however, difficulty was experienced as the vessels were thickly matted with adhesions and they had to be dissected back to the main vessel. Close proximity with the recurrent Laryngeal nerve made this part of the operation rather trying and tedious. Bands of adhesions, uniting the lobe of the gland to the structures behind were exceedingly vascular, which necessitated ligating before they were cut. For this purpose an Aneurysm needle, armed with a double number 3 ten day Chromic cat-gut, was used and portions at a time were tied, the whole being encircled by a second ligature. The isthmus alone held the tumor, with the exception of the above mentioned portion which extended below the Clavicle and which we did not deem it advisable to remove since it produced no pressure on the Trachea or Recurrent nerve nor was it disturbing the natural conformity of the neck.

This part was also left undisturbed for the reason that the man's physical robustness and age were against an exceedingly prolonged operation. By crushing the isthmus and lower part of this lobe by a large heavy

clamp (as is seen in picture 2) hemorrhage of any degree was arrested during division.

A continuous number 3 Chromic Cat-gut suture was now passed from one end of the cut surface to the other. Hot compresses sufficed to control what little oozing occurred.

The tumor thus removed measured 4 1-2 inches across its greater diameter and weighed 1¼ pounds. Silk worm gut was used to suture the wound and a cigarette drain was left "in situ" for possible post-operative hemorrhage.

The patient was returned to the ward, having been under the anaesthetic for 2 hours and 20 minutes. His condition when regaining consciousness was quite satisfactory and he remained quietly in bed, temperature 104.4; pulse 96.

Second day after operation—

Patient somewhat disturbed and restless. Inflammation and infiltration in the surrounding tissues. Temperature 100.3; pulse 97.

Third day—

Patient quiet, temperature 98; pulse 78.

Fourth day—

Temperature and pulse normal. Some discharge of a serous nature present. Patient was put on Thyroid extract grains x, daily. He continued very well until the 10th day, when he became somewhat weaker; temperature fell below normal, pulse 110, weak and arythmic. Patient disturbed and restless, hypodermics of digitalin, grains 1-50, were given every 6 hours. Thyroid extract was increased to grains xxx, daily.

On the twelfth day patient's condition became serious, temperature 96.3; pulse 100 and weak. Hypodermics of whiskey, in which Thyroid extract, grains x, was dissolved,

Fig. 2.—Tumor exposed; Isthmus clamped, and cut; Tumor ready for removal.

were given every two hours alternating with digitalin, grains 1-50. This treatment was continued for three days, during which time patient showed gradual improvement. The Thyroid extract was reduced to grains x morning and evening. The patient was given full diet and gradually progressed to a favorable recovery.

THE TRAUMATIC PSYCHOPATHIES.

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ONE need not be long present at any of our Hospitals for the Insane before he shall have observed that, in a considerable proportion of the admissions, a previous head injury is given as a probable or possible cause of the mental trouble. There can be little doubt that, in many of these cases, the injury has not been a factor in the causation of the condition, yet in others it seems possible that it may have been, at least, a predisposing or exciting factor and, finally, there are the true traumatic cases which we feel reasonably certain are due entirely to the injury. Traumatic psychoses appear to possess less of interest than many of the other forms of insanity, at any rate they are less frequently reported. However, there are some factors in connection with them that are worthy of consideration and a presentation of some of these with brief cases reports in illustration of the same may be justifiable.

The forms of mental disturbance that may follow trauma show considerable variation, and Adolf Meyer has offered a provisional classification for these, in which he recognizes five distinct groups. In the first he places the cases of direct post-traumatic deliria, which also includes certain protracted delirious states, sometimes associated with alcoholism or senility. In the second are placed cases known as the post-traumatic constitution; some patients subsequent to their injury exhibiting an increased susceptibility to the deleterious effects of alcohol, exposure to the sun's rays, unusual mental stress,

etc., others manifesting hysteroid or epileptoid episodes, and in some cases there develops a paranoid state. The third group includes those cases showing defect conditions, commonly aphasias, epilepsy, either Jacksonian or generalized, and also post-traumatic progressive mental deterioration. Frequently the trauma is an exciting factor in the development of a psychosis such as dementia paralytica, and these comprise the fourth class, while finally we have those cases in which there appears a post-traumatic psychosis, the injury having not directly affected the head.

Some authors describe a post-traumatic symptom-complex and although it is now conceded that a definite post-traumatic psychosis does not exist, many patients, subsequent to head injury, manifest symptoms and present certain features which collectively are more or less distinctive. The necessity of deciding whether a given case should be placed among the purely traumatic or among one of the other groups such as the Manic Depressive, Dementia Paralytica, etc., not uncommonly occurs, and probably where this difficulty arises Dementia Paralytica is more frequently and closely simulated than any of the others. In this regard it is necessary to keep in mind that an injury in some cases seems to be the exciting factor in the development of Dementia Paralytica, but where the latter condition exists the periods of marked excitement, the more or less characteristic delusions, the speech defects, the pupillary changes, and in more difficult cases the rapid course of the disease, will assist in making the diagnosis clear.

The anatomical changes found in Traumatic Insanity are both focal and diffuse. At the site of injury there may be depression, haemorrhage, laceration and destruction of brain tissue, while later, diffuse encephalitic changes are found; gliosis, hyaline and fatty degeneration, the presence of small cysts, etc.

Definite mental disturbance, after the immediate effects of the injury have disappeared, may not become evident for weeks or months, although it is probable that in most cases prodromal symptoms are present. In other instances, following the period of unconsciousness, traumatic delirium occurs. Here consciousness is clouded and the patient confused, he does not recognize those about him, neither can he tell where he is, nor the year, month or day. Thought is difficult and amnesia for events at the time of the accident is common, even happenings more remote may be almost or quite forgotten. He is easily excited, or may be apathetic, and often a tendency to fabrication is evident. This state, in which the patient asserts that he is perfectly well, occasionally lasts for weeks, after which recovery may occur or there may be a gradual transition into a condition known as the post-traumatic constitution (Meyer). If the latter, which is often termed traumatic dementia, appears, we have presented to us a fairly definite clinical picture. Gradually evidences of progressive mental failure appear. Memory becomes defective, there is a diminished power of application and the patient tires easily, irritability is often a pronounced feature and there is more or less constant bad humor. He may complain of peculiar sensations in the head, buzzing in the ears, dizziness, etc. He probably becomes self-centered and indifferent to the happiness, comfort and rights of others. There is frequently a tendency to over-indulgence and excesses, to the ill effects of which he is very susceptible.

Certain patients ultimately suffer from epileptic convulsions, either of the localized or generalized variety, in conjunction with the usual associated conditions of epileptic befogged states, ill-humor, and epileptic excitement.

The mental symptoms are more likely to occur and the disease to run a pronounced course where there has been, previous to the injury, evidences of mental instability or

a history of alcoholism, syphilis, or arterio-sclerosis. The physical symptoms presented in the traumatic psychoses of course show considerable variation, depending on the nature, extent, and location of the focal lesions; tremor or paresis of certain muscle groups, exaggerated reflexes, speech disorders, and in rare cases immobility of the pupils, etc. The disease often results in a profound degree of dementia and for a time runs a progressive course, ultimately showing arrest however, and death usually results from some intercurrent illness. Early operation to relieve pressure is occasionally beneficial, but when signs of dementia have occurred such procedure carries far less likelihood of improvement.

Case 1.—R.H.C., male, age 34; admitted June 26th, 1910.—Family History negative. Patient was a healthy, well developed child, learned readily and had no severe illnesses. He married at 25 and has one child which is apparently normal. He has always lived upon a farm, and although not a total abstainer has been very temperate in the use of alcohol, and was always regarded by those who knew him as normal in every way. He enjoyed good health until March 12th, 1910, on which day he was struck with a stick on the head, following an altercation with a neighbor. He became confused but was not rendered unconscious and reached home unassisted. He rested most of the day and towards evening convulsive seizures occurred, which his wife describes as resembling "chills." He knew when these were about to occur and would exclaim "I am going to have another attack," and while the condition lasted, he did not lose consciousness. At the same time anorexia and sleeplessness were present and he complained of indefinite pains in the head. He fretted considerably and scolded his wife for not calling the physician sooner. When seen by the latter the condition was diagnosed as "concussion of the brain." The convulsive seizures soon disappeared, but since the injury his friends describe him as "a changed man." He became sad

and very irritable, especially towards those of whom he had previously been very fond, and was unable to apply himself to any work. With the exception of the above changes nothing of note was observed, and there seemed to be no sufficient reason for his not attending camp as had been his custom. While at camp the weather was warm and he was often exposed to the direct heat of the sun. On June 7th, while still there, his comrades noticed that something was wrong. He became more depressed and acted as if others were against him. He asked what wrong he had done, and expressed a desire to make reparation for his misdeeds. During the night excitement was pronounced and restraint necessary. No improvement occurred and he was admitted to the Hamilton Hospital for Insane 19 days later. On admission he showed that he had lost considerably in weight recently. He was more or less constantly clouded and it was almost impossible to make him understand any question that was asked, his usual response being "what." At times he mimicked dogs and chickens, he was restless, wandered about his room, did various acrobatic feats, moved his bed from place to place and climbed up the window. His memory showed marked impairment, and it was almost impossible to gain his attention. At times he was clearer and could tell something of past events. Physically, there was a slight scar and under it a narrow bony ridge about 3-4 inch in length in the left frontal region just above the hair line, directly back from the middle of the upper margin of the orbit. There was a slight bradycardia and the left pupil was only capable of dilating up to a certain degree. The patellar reflexes were much exaggerated.

Case 2.—D.B., male, age 51; admitted to Hospital March 17th, 1913.—In the family history there is no evidence of mental or neurotic taint, and the parents were not related. Birth and early life were normal. He received no education, and the greater part of his life was spent in the bush as lumberman and fire-ranger. He has

been married twice. About two years previous to his admission he came to Toronto and he and his wife kept a boarding house. One night he became enraged at one of the boarders who was intoxicated, struck him and death resulted. Upon admission patient weighed 170 pounds and was 5 ft. 8 in. in height. There was a scar about 6 inches in length, extending from the centre of the right eyebrow upward into the hairy scalp. The pupils were unequal and the left was irregular and pear shaped, they reacted to light and accommodation. Both hands and the right leg showed a tremor and the tongue was tremulous on protrusion, knee jerks were both exaggerated, the right more than the left. The Rhomberg sign was said to have been present. Patient admitted the use of alcohol and said he had been intoxicated on four or five occasions. Venereal disease was denied. The Wassermann test was negative. The patient says that 22 years ago he was injured in a log-jam, the right side of his skull having been fractured and the arm and leg bones broken in many places. Following this accident he was in hospital for 20 months. Since then he said he had never been the same man, and during the winter following his discharge from the hospital he was nearly frozen by falling into the river. He did not return to work for another year and was in bed for a considerable portion of that time.

Previous to his injury he seems to have been a capable, steady man and did contract work, subsequently he followed the same kind of work for some years, but in a much less efficient way, for, according to his own account, he has since that time had very little confidence in his own ability. Under the slightest stress or unusual excitement he would become confused, in his own words "go all to pieces," and at such times seemed to lose all power of self-control. His expression is worried and at times he is unusually irritable. There is a pronounced emotional

instability and he often cries upon the most trivial provocation. While in hospital his condition improved, he usually slept well and gained in weight. At times he became restless, sleepless and depressed. The excitement of a patient, or the admission of a new one, would often cause him a great deal of worry, and at these times the tremor was more evident. By January, 1914, he had regained considerable self-control, and his emotional tone was much more stable; in fact, the degree of improvement was such that he was then considered to be probably in as good health mentally as he had been for some years.

Case 3.—J.B., male, age 46; admitted to Hospital April 25th, 1915. In October, 1914, while on a holiday, he was struck by a street car, his skull being fractured, and following the accident the skull was trephined. After remaining in the hospital for about two months he returned home and resumed his duty as Police Court Clerk. He appeared to have made a good recovery, but, after the lapse of two weeks, he showed evidences of mental failure in an increased incapacity for work and marked memory defects, so that it was soon necessary for him to relinquish his duties. Since that time the above symptoms have been progressive, depression has been pronounced, and he has been unable to follow any employment. Early in April, 1915, while out walking, he is said to have fallen, and subsequent to this he became much worse. On April 25th he said that he and his wife were about to be tortured, feared anyone who approached him, and expressed suicidal tendencies.

He was admitted to Hospital, and examination disclosed the following condition: he was in a stuporous condition, made no reply when spoken to, and was quite indifferent and apathetic. At times he has been clearer mentally and has answered questions asked him. He thinks that he received an injury, but is not certain,

because others are "mesmerizing" him and may have suggested the idea to him. He is in constant fear, says that he can hear helpless children crying as they are being murdered, and insists that he himself is about to undergo a slow torture. Occasionally he refuses food, as he says it contains poison, and restlessness and irritability are frequent. He is unable to tell when he was injured or how long he has been here, does not know his age and has only a hazy appreciation of the status of those about him. His appearance, words and actions are indicative of mental confusion, and thought requires great effort. On one occasion immediately following an examination, during which he answered questions fairly readily but at the same time exhibited considerable irritability, he became clouded, made no response to questions, and failed to apprehend events happening about him. This condition lasted for probably ten minutes, after which he gradually became clearer. Two inches behind the outer angle of the left orbit and half an inch upwards is a circular depressed area about one inch and a quarter in diameter which shows a pulsation synchronous with the heart-beat. Passing downwards and backwards over this area is a linear scar one inch and a half in length. The pupils are regular and dilated, the left larger than the right, and both react slowly to light and accommodation. There is a hesitancy in speaking, and tremor of the lips is present at such times. During voluntary effort there is tremor of the extremities and also of the tongue upon protrusion. The knee jerk is exaggerated on either side.

The above three cases afford examples of some of the mental changes that may occur as the result of head trauma. In the first case a patient for three months subsequent to his injury, although not his former self, was able to attend camp, and then, following prolonged exposure to the heat of the sun while there, acute mental disturbance occurred, the termination of which has been a profound dementia. In the second case, many years

after the accident, there are periods when the patient, under moderate stress or undue excitement, appears to lose his power of self-control; later, however, his condition approaches the normal, and happily the end result in this patient is not that of dementia. In the third case, the man, following his injury, made an apparent recovery, but, after the lapse of a few weeks, the onset of progressive mental failure occured, until now, less than one year since his accident, he has reached an advanced stage of dementia.

ANNUAL EXAMINATION OF NURSES AT ONTARIO HOSPITALS FOR THE INSANE.

THE successful nurses at the examinations held at the different Hospitals in the month of May are as follows:

Brockville—Dr. J. C. Mitchell, Medical Superintendent. Juniors—H. Farnsworth, Edna Mustard, Hannah Neilson, Gertie Perro, Mertie Perro, Nellie Ritchie. Intermediates—Tena Bedard, Mary Beatty, Maria Burns, Margaret Gavin, Reta Hanna, Elsie Lackey, Lulu Sunderland, Ethel Wilson. Seniors—Agnes Carl, Pearl Humphreys, Edith Morton, Elma Mustard, Ida Perrin.

Kingston—Dr. E. Ryan, Medical Superintendent. Juniors—Louise Dwyer, Mina Eady, Nellie Fowler, Alice Juniper, Evelyn Keill, Eileen Trousdale, Mabel Trousdale, Alberta Snider. Intermediates—Bessie Greenfield, Bella Kennedy, Elma Kennedy, Phyllis Murphy, Margaret Scott, Carrie Vanalstine. Seniors—Rose Daley, Margaret Fay, Mary Forrester, Monica Hughes, Ethel Holmes, Zella Lindsay, Ethel Lunman, Mae McKenna, Mary Moran, Mae Murphy, Mary O'Brien, Mabel Kellar.

Toronto—Dr. J. M. Forster, Medical Superintendent. Juniors—Leah Cascanet, Ellen Franklin, Helena Hancock, Elizabeth Hendry, Margaret Lawless, Lillian Millard, Maggie Patterson, Mary Rainey, Gertrude Reddy, Ada Scott, Mary Thompson, Margaret Wilson. Intermediates—Mary Adshead, Julia Broderick, Alice Deer, Louisa Henry, Charlotte McDonald, Amy Peake, Pansy Paine, Jane Reilly, Jane Ronald, Elizabeth Sheehan, Edith Thomas, Elizabeth Turner, Ida A. Turner, Margaret Thomas, Sarah Warden, Jessie Whitelaw, Isabella Wylie. Seniors—Alice Adshead, Susanna Campbell, Beatrice Cobbett, Letitia Dodds, Mary Walker.

Mimico—Dr. N. H. Beemer, Medical Superintendent. Juniors—Elizabeth Annand, Lizzie Doverty, Theresa

Haughton, Jessie Halliday, Mina Krause, Lucy Lee, Mary McKenzie, Eugene Russell, Clara Tipler. Intermediate—Jessie Milne. Seniors—Jessie Milne, Cecelia Podmore, Christina Thompson, Etta Wilson, Ella McIlwain.

Hamilton—Dr. W. M. English, Medical Superintendent. Juniors—Elsie Carr, Alice Cousins, Gertrude K. Evans, Florence A. Fish, Lillian M. Fish, Annie Guyer, Clarice E. Hibbert, Helen W. Kelly, Lizzie Mairs, Florence E. Parrick, Edith Ponting, Nora Race, Mary Thomas Sarah Thomas, Etta L. Tully. Intermediates—Alberta J. Cave, Sadie Denvir, Kathleen Douglas, Lucy Holgate, Ethel P. W. Jillings, Alice Jones, Laveania M. Kelly, Anna Letts, Hope Swan, Muriel Thompson, Mary Whittingham. Seniors—Florence M. Clayson.

London—Dr. W. J. Robinson, Medical Superintendent. Juniors—Daisy Allen, Eva C. Bonnell, Mary K. Clark, Jessie P. Hughes, Marguerite Fogarty, Bessie Kennedy, Dora Leonard, Adeline McGuire, Jean McQueen, Jean D. Mason, Maude C. Morton, Jessie M. Orrell, Isabella Payne, Clara M. Yorke. Seniors—Margaret Bishop, Alice Fitzgerald, Alice Mackey.

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